REQUEST FOR EXTRAORDIANRY FUNDING
CHECKLIST AND FINDINGS

Name_____ Date of Request_____

CDDO_____ CSP_____

Tier Rate_____

☐ Summary Page: page 2

☐ Equipment and Supplies Form: page 3

☐ Direct Care Staffing Form: Day Services - pages 4A and 4B (if applicable)

☐ Direct Care Staffing Form: Residential Services - pages 4C and 4D (if applicable)

☐ Average Hourly Wage Calculation Worksheet: page 5A and 5B
OR payroll forms

☐ Threshold Calculation Sheet: page 6

☐ Justification for Special Tier Rates: page 7

☐ Person Centered Support Plan

☐ Behavior Support Plan (if applicable)

☐ Summarized and interpreted behavioral data (if applicable)

☐ Health Information (if applicable)

☐ Summarized health data with health care professional's recommendations (if applicable)

Findings:

Approved ☐ yes ☐ no

Comments:

Signature_____ Date_____